

REPORT ON EXAMINATION

of the

HEALTH 1-2-3, INC.

NASHVILLE, TN

RECEIVED

SEP 10 2004

Dept. Of Commerce & insurance
Company Examinations

as of

DECEMBER 31, 2003

DEPARTMENT OF COMMERCE AND INSURANCE

STATE OF TENNESSEE

NASHVILLE, TENNESSEE

TABLE OF CONTENTS

<u>Item</u>	<u>Page</u>
Salutation	one
Introduction	1
Scope of Examination	1
Company History	2
Growth of Company	4
Charter and Bylaws	4
Management and Control	6
Corporate Records	7
Fidelity Bond and Other Insurance	7
Territory	8
Plan of Operation (includes inforce by state)	8
Market Conduct Activities (Review of Insurance Products and Related Practices)	9
Excess Loss Agreement	10
Retirement Plan and Other Employee Benefits	12
Loss Experience	12
Accounts and Records	12
Statutory Deposits	13
Agreements with Parent, Subsidiaries and Affiliates	14
Pecuniary Interest - Tenn. Code Ann. § 56-3-103	14
Commission Equity	15
Dividends or Distributions	15
Litigation	15
Subsequent Events	15
Financial Statement	16
Analysis of Changes in Financial Statement and Comments Resulting From Examination	20
Comments and Recommendations	21
Conclusion	22
Affidavit	23
Organizational Chart	24

Nashville, Tennessee
September 10, 2004

Honorable Paula A. Flowers
Commissioner
State of Tennessee
Department of Commerce and Insurance
Nashville, Tennessee 37243

Dear Commissioner:

Pursuant to your instructions and in accordance with Tennessee insurance laws, regulations, and resolutions adopted by the National Association of Insurance Commissioners (NAIC), a financial examination and market conduct review was made of the condition and affairs of the

HEALTH 1-2-3, INC.
NASHVILLE, TENNESSEE

hereinafter and generally referred to as the HMO, and a report thereon is submitted as follows:

INTRODUCTION

This examination was called by the Commissioner of Commerce and Insurance of the State of Tennessee and commenced on June 7, 2004. The examination was conducted under the association plan of the NAIC by a duly authorized representative of "The Department of Commerce and Insurance", State of Tennessee.

SCOPE OF EXAMINATION

This examination report covers the period from December 31, 2001, the date of the last previous examination, to the close of business on December 31, 2003, and includes any material transactions and/or events occurring subsequent to the examination date and noted during the course of the examination.

The examination of the financial condition was conducted in accordance with guidelines and procedures contained in the National Association of Insurance Commissioners (NAIC) Examiners Handbook. During the course of examination, assets were verified and valued and liabilities were determined and estimated as of December 31, 2003. The financial condition of the Company and its amount of solvency were thereby established. Test checks were made of income and disbursement items for selected

periods, and a general review was made of the Company's operations, practices, and compliance with applicable statutes and regulations. All asset and liability items contained in the financial statement of this report were examined and verified with relative emphasis according to their amount and potential impact on capital and surplus.

In addition, the following topics were reviewed:

- Company History
- Charter and Bylaws
- Management and Control
- Corporate Records
- Fidelity Bonds and Other Insurance
- Territory
- Plan of Operation (includes inforce/premium by state)
- Market Conduct Activities (includes privacy statement)
- Excess Loss Agreement
- Retirement Plan and Other Employee Benefits
- Loss Experience
- Accounts and Records
- Statutory Deposits
- Agreements with Parent, Subsidiaries and Affiliates
- Pecuniary Interest - Tenn. Code Ann. § 56-3-103
- Commission Equity
- Dividends or Distributions
- Litigation
- Subsequent Events
- Financial Statement

The previous examination was originally conducted as of December 31, 1999, suspended as of September 8, 2000 and updated as of December 31, 2001 by authorized representatives of "The Department of Commerce and Insurance", State of Tennessee. The last previous examination resulted in no change in surplus and made no recommendations. There were no Department requirements arising as a result of such examination.

COMPANY HISTORY

The HMO was incorporated on June 9, 1994, as a for profit corporation pursuant to the provisions of the Tennessee General Corporation Act, under the name of "HealthOne, Inc.". An amendment to the Charter dated June 23, 1994 changed the name of the HMO to Health 1·2·3, Inc. and was filed with the Secretary of State on November 2, 1994. Effective December 30, 1994, the HMO was issued a Certificate of Authority by "The Department of Commerce and Insurance", State of Tennessee, to transact the

business of Health Maintenance. The HMO provided delivery of HMO (health maintenance) and PPO (preferred provider) products to the group health market in Middle Tennessee.

Effective, May 13, 1998, TriPoint Health Plan, Inc. was merged with the HMO. The Surviving Corporation is Health 1·2·3, Inc. TriPoint was licensed in Arkansas and Kentucky. In January, 1999, the Certificate of Authority for Arkansas was surrendered. TriPoint had no members in Kentucky at the time of the merger.

TriPoint Health Plan was incorporated on February 8, 1995, as a for profit corporation pursuant to the provisions of the Tennessee General Corporation Act, under the name of "TriPoint Health Plan, Inc.". Effective November 16, 1995, the Company was issued a Certificate of Authority by "The Department of Commerce and Insurance", State of Tennessee, to transact the business of Health Maintenance as defined in Tenn. Code Ann. § 56-32-202. Effective July 2, 1996, the Company was issued a Certificate of Authority to operate as a health maintenance organization in the state of Arkansas. Effective October 14, 1996, the Company was issued a Certificate of Authority to operate a health maintenance organization in the state of Kentucky. The Company provides delivery of HMO (health maintenance) and PPO (preferred provider) products to the group health market in West and East Tennessee and selected counties in Kentucky. At December 31, 1997, the Company had no members in Arkansas.

TriPoint was wholly owned by Vanderbilt Management Services, Inc. (formerly THG Management Services, Inc.) which was a subsidiary of Health 1·2·3, Inc. The ultimate parent is Vanderbilt University.

The surviving HMO (Health 1·2·3, Inc.) is currently 100% owned by Vanderbilt Health Services, Inc. which is 100% owned by Vanderbilt University.

In June 2000, the HMO notified the Healthcare Financing Administration (HICA) that effective January 1, 2001 the HMO would no longer participate in the Medicare Choice Program. The HMO had zero Medicare members by January, 2001 a drop of approximately 9400 members from December, 2000. In August 2000, the HMO announced its intention to exit its Commercial HMO operations. In January 2001, it had only 2400 commercial members a drop from approximately 34,000 members in December, 2000. All memberships expired by April 1, 2001.

Based upon a Stock Purchase Agreement dated November 1, 2000, between Health Plan Holding Corporation and Vanderbilt Health Services, Inc., the HMO ultimately became 100% owned by Vanderbilt Health Services, Inc. In previous years, Vanderbilt Health Plans Inc. had owned 92% of the stock and Vanderbilt Management Services, Inc. owned 8% of the stock. These two entities were both owned by Vanderbilt Health Services, Inc. The Stock Purchase Agreement did not require "Department of Commerce and Insurance" approval since ultimate control (Vanderbilt University) never

changed and the HMO was merely dividended to Vanderbilt Health Services, Inc. Discussion of any related contracts for management or services is listed under the caption: "Agreements with Parent, Subsidiaries and Affiliates".

At December 31, 2003, the HMO was licensed in one state, Tennessee.

GROWTH OF COMPANY

The following exhibit depicts certain aspects of the growth and financial history of the HMO since the previous examination, according to annual statements filed with "The Department of Commerce and Insurance", State of Tennessee.

<u>Date</u>	<u>Net Premium Income</u>	<u>Medical & Hospital Expenses</u>	<u>Admitted Assets</u>	<u>Liabilities</u>	<u>Net Worth</u>
12/31/02	0	(\$1,799,106)	\$13,044,306	\$231,978	\$12,812,328
12/31/03	0	(179,009)	1,762,435	0	1,762,435

The negative amount of medical and hospital expenses is due to the favorable development of claim reserves as claims pay out from the business runoff. As of April 1, 2001, the HMO had no members. Net worth declined due to dividends paid to stockholder discussed under the caption, "Dividends or Distributions".

CHARTER AND BYLAWS

Charter:

The original Charter of the Company was filed and recorded with the Tennessee Secretary of State on June 9, 1994. Said Charter establishes the Company as a for profit corporation. It does not state that the corporation has a perpetual existence. The objects and purposes for which the said corporation is organized, and the natures of its powers and of the business to be carried on by it, are as follows:

- (a) To transact the business of a health maintenance organization, as defined in Tennessee Code Annotated, Title 56, Chapter 32.
- (b) To do all things which the Board of Directors determines to be necessary or appropriate in connection or associated therewith.
- (c) To engage in any lawful business.

The Charter was first amended June 23, 1994 at which time the name of the Corporation was changed from "HealthOne, Inc." to Health 1·2·3, Inc. The second amendment was on July 27, 1994 at which time the par value of the 1,000,000 shares of authorized common stock was changed from \$0 par to \$1 par value per share and additional language was added to Part 8 to add "however, nothing contained in this charter shall exempt an officer or director from any provision of Title 56, TCA as it may be amended, supplemented or superceded".

An Amended and Restated Charter was filed and recorded on November 2, 1994 with the Tennessee Secretary of State which effected the above changes and changed the number of authorized shares of common stock from 1,000,000 to 100,000 shares. On March 31, 1995, Application For Registration Of Assumed Corporate Name was filed and recorded with the Tennessee Secretary of State which added the assumed corporate name of Health 1·2·3 Platinum.

An Amended and Restated Charter was filed and recorded with the Tennessee Secretary of State on August 22, 1997 and the Register of Davidson County, Tennessee on August 27, 1997 which changed the principal office address to: 706 Church Street, Suite 500, Nashville, Tennessee 37203. The Amended and Restated Charter additionally changed the name of the registered agent, name of the incorporator and address of incorporator. "The Department of Commerce and Insurance" approved said Amended and Restated Charter on July 16, 1997.

Articles of Amendment to the Charter dated April 6, 2000 were approved by "The Department of Commerce and Insurance" on April 27, 2000 which changed Article Six to state:

"6. The number of shares of stock the corporation is authorized to issue is One Hundred Eight Thousand, Six Hundred Ninety Five (108,695) shares of Common Stock, par value of One Dollar (\$1.00) per share."

Bylaws:

The Amended and Restated Bylaws of the Company in effect at December 31, 2003 were adopted by the unanimous consent of the shareholder on November 30, 1995 in order to increase the number of directors to 15. The original Bylaws were filed and recorded with the Tennessee Secretary of State on June 9, 1994. Such Bylaws may be amended, altered, repealed or restated, and new Bylaws adopted by the affirmative vote of a majority of the stock represented at such meeting, or by the affirmative vote of a majority of the members of the Board of Directors who are present at any regular or special meeting.

The Bylaws state that the Company may have offices, either within or without the State

of Tennessee, as the Board of Directors may designate or as the business of the Company may require.

An annual meeting of shareholders shall be held on such date and place as may be determined by the Board of Directors. Special meetings of the shareholders may be called by the Board of Directors or holders of at least ten percent (10%) of all the votes.

A Board of Directors of at least three (3) and not more than fifteen (15) members shall be elected by the shareholders at the annual meeting. Regular meetings of the Board of Directors may be held with or without notice; however, special meetings require notice of at least twenty-four (24) hours.

The Officers of the Company shall be chosen by the Board of Directors and include President, Secretary and such other officers as may be appointed.

MANAGEMENT AND CONTROL

Management:

The Bylaws provide that all corporate powers shall be exercised by or under the authority of and the business and affairs of the HMO managed under the direction of the Board of Directors consisting of at least three (3) and not more than fifteen (15) persons. Board members are elected by the shareholders. As of December 31, 2003, the Board of Directors of the Company was composed of the following:

Harry R. Jacobson, MD
J. Richard Wagers, Jr.
Norman B. Urmey

As of December 31, 2003, the following persons held office in the Company:

Norman B. Urmey	President
J. Richard Wagers, Jr.	Secretary

The administrative and executive functions of the HMO are performed by staff provided by Victory Management Services, Inc. under recitals of a service agreement. The relationship with the mentioned firm is discussed under the heading "Agreements with Parent, Subsidiaries and Affiliates". Certain services were purchased in past years from outside contractors if needed and were not available from in house personnel. Such services included actuarial analysis and independent audit. "The Department of Commerce and Insurance" exempted the independent audit report and actuarial analysis for 2003 due to the HMO now being only a shell company with no members since April 1, 2001 and having no active open claims. Further discussion is contained

under the caption "Accounts and Records".

Control:

The HMO is 100% owned by Vanderbilt Health Services, Inc. which is 100% owned by Vanderbilt University.

A holding company organizational chart is included at the last page of this examination report.

CORPORATE RECORDS

Minutes of meetings of the shareholders and Board of Directors of the Company were reviewed for the period under examination. In general, such minutes appear to be in proper order and accurately report the proceedings of each respective meeting.

Tenn. Code Ann. § 56-3-301 (b) (1) states "No investment or loan, except policy loans, shall be made by any such life insurance company unless the same first has been authorized by the board of directors or by a committee appointed by such board and charged with the duty of supervising such investment or loan". The Board of Directors has delegated this authority to Victory Management Services, Inc. which currently manages the HMO under recitals of a service agreement. This is due to the fact that the only security owned by the HMO is a FNMA bond which is pledged as a trust deposit to "The Department of Commerce and Insurance", State of Tennessee. The HMO is in runoff with no active enrollees since April 1, 2001. Reviews of financial statements of the HMO are made monthly by the Board of Directors of Vanderbilt Health Services (parent company).

FIDELITY BOND AND OTHER INSURANCE

Officers and directors of the HMO are covered by a policy with named insured, Vanderbilt University which lists the HMO under Medical Center (wholly owned or controlled entities). The following is a schedule of the enumerated coverages at December 31, 2003:

<u>Type of Coverage</u>	<u>Coverage Limits</u>
1. Employee Theft Coverage	\$10,000,000
2. Premises Coverage	\$10,000,000
3. Transit Coverage	\$10,000,000
4. Depositor's Forgery Coverage	\$10,000,000

5. Computer Theft and Funds Transfer Fraud Coverage \$10,000,000

Each of the above coverages has a \$50,000 deductible.

Coverage is underwritten by Federal Insurance Company which is licensed in Tennessee as a "Foreign Property and Casualty Insurer".

The HMO's fidelity bond coverage exceeds the suggested minimum as exhibited in the NAIC Financial Condition Examiners Handbook and complies with Tenn. Code Ann. § 56-32-206 (b). The HMO has no employees.

TERRITORY

As of December 31, 2003, and as of the date of this examination report, the Company was licensed to transact business in the State of Tennessee. The Certificate of Authority for that jurisdiction was reviewed.

The Company's service area in Tennessee consists of the following counties:

Fayette	Henry	Shelby	Coffee
Hickman	Robertson	Williamson	Claiborne
Jefferson	Roane	Haywood	McNairy
Bedford	Franklin	Maury	Trousdale
Campbell	Hamilton	Monroe	Unicoi
Henderson	Perry	Cheatham	Giles
Montgomery	Warren	Carter	Hawkins
Morgan	Washington	Hardin	Madison
Weakley	Dickson	Marshall	Sumner
Blount	Hamblen	McMinn	Sullivan
Gibson	Houston	Stewart	Davidson
Lawrence	Rutherford	Wilson	Fentress
Knox	Scott	Hardeman	Humphreys
Wayne	DeKalb	Lewis	Smith
Anderson	Greene	Loudon	Sevier

PLAN OF OPERATION

The Company was incorporated as a Health Maintenance Organization to provide managed healthcare services to businesses in Nashville and the surrounding areas. Monthly premium payments were made for rendering or arranging necessary medical service for the employees of the employer groups with which the Company contracts. The Company additionally provided managed care services to residents of Tennessee

participating in the Medicare program under the name of Health 1 2 3 Platinum. Under this program, a monthly-prepaid capitated payment from the Health Care Financing Administration (HCFA) is paid in return for rendering or arranging medical services for the enrolled Medicare participants.

The HMO currently plans to write no premium and provide no medical care coverage. The trust deposits and assets associated with them have been maintained as income producing investments in compliance with Tenn. Code Ann. § 56-32-212 in order for the HMO to maintain its certificate of authority. As of April 1, 2001, the HMO had no members.

Enrollment History:

<u>Year</u>	<u>Members</u>
2002	0
2003	0

During 2003, the Company wrote no direct premium.

<u>State</u>	<u>Amount</u>
Tennessee	\$0

MARKET CONDUCT ACTIVITIES

In accordance with the policy of "The Department of Commerce and Insurance", State of Tennessee, a market conduct review was made of the Company as of December 31, 2003 in conjunction with this examination. However; the review is a moot issue due to the fact that the HMO has no market activities and writes no business. The following items were addressed:

Filing and Approval of Policy Forms:

The HMO has no active policy forms and has not issued a policy since 2001. All memberships had expired by April 1, 2001. The HMO is aware of the filing responsibility for various forms, agreements, etc., as well as "hold harmless" requirements for provider contracts pursuant to Tenn. Code Ann. § 56-32-205 (c) in the event the HMO becomes active in the future.

Underwriting:

The HMO has not written any business since 2001 and does not intend to do so. No rate or underwriting manuals are maintained due to the HMO's inactive status.

Advertising:

No advertising is done by the HMO due to its inactive status.

Claims Review:

The HMO has no active or contingent claims. All claims were fully developed. The Company exhibited negative dollar (redundant) claim development during the calendar year, 2003 and 2002 as reserves were released after all claims and recoveries were settled.

Prompt Payment - Tenn. Code Ann. § 56-7-109

Review of "Prompt Payment Standards" pursuant to Tenn. Code Ann. § 56-7-109 is a moot issue. All claims were fully developed and paid as of the close of the 2001 calendar year. No business has been written since 2001 and no active claims exist. The HMO is subject to Tenn. Code Ann. § 56-32-226 which references the above statute and is therefore in compliance.

Privacy Policy:

The HMO writes no business and has no enrollees; therefore, a privacy statement pursuant to Tenn. Comp. R. & Regs. Tit. Dep't of Commerce and Ins., ch. 0780-1-72 would not apply.

Policyholder Complaints:

Inquiries made to the various sections within "The Division of Insurance" indicated no concerns or complaints with the HMO during the period under examination.

EXCESS LOSS AGREEMENT

On September 1, 1997, the Company entered into an Excess Risk Insurance Contract with Allianz Life Insurance Company of North America effective until terminated. The Excess Risk Coverage to be provided under the above agreement is as follows:

- A. For Eligible Hospital Services the Deductible amount for such Excess Risk

Coverage is \$100,000 of the Loss for each Member for each Contract Year. Once the Deductible has been satisfied, the reinsurer shall indemnify the Company for:

1. 90% if services are performed in a "per diem" or approved fixed procedural fee hospital;
 2. 80% if services are performed in any other hospital.
- B. The excess Loss for Eligible Hospital Services in that Contract Year for expenses related to organ and bone marrow transplant therapy shall be reimbursed as follows.
1. 90% if services are performed in a LifeTrac facility with a Prior Approved Transplant Reimbursement Schedule for that confinement.
 2. 80% if services are performed in hospital with a Prior Approved Transplant Reimbursement Schedule for that confinement.
 3. 50% if services are performed in any other hospital.
 4. 50% for organ and bone marrow Retransplantation Services performed in any hospital.
- C. In the event an excess Loss could be indemnified under more than one of the above subsections, the subsection providing the least indemnity shall apply.
- D. Except as indicated here, expenses incurred at hospitals having "per diem" arrangements with the Company shall be reimbursed on the basis of the hospital's actual charges to the Member or Plan, in an amount not exceeding the "per diem" rate. Hospitals with outlier or stop loss provisions in which "per diems" revert to a discount off actual charges or fee for service charges shall not be considered "per diem" hospitals once the outlier or stop loss threshold is reached.

Per Diem Hospitals

Commercial Per Diems:

Per Diem Limits (Per Day)

Subject to a maximum of \$2000 per day

Medicare DRG's are subject to the \$2,500 Maximum Daily Average.

Transplants performed at Vanderbilt University Medical Center shall be considered a Prior Approved Transplant Schedule for that confinement and reimbursed at 80% subject to the transplant terms.

- E. Notwithstanding the above, the overall maximum indemnity payable during the life of this Excess Risk Insurance Contract for Eligible Hospital Services for each Member shall be \$2,000,000.

The Excess Risk Insurance Contract was not signed by the parties; however, it has been implemented through a letter of agreement dated July 2, 1997 agreed to by the Company dated July 15, 1997. A "Compensation Agreement" was signed September 12, 1997 by the reinsurer and October 6, 1997 by the Company.

Allianz Life Insurance Company of North America is licensed in Tennessee as a "Foreign Life Insurer"

The above styled agreement has terminated with the runoff of the business of the HMO. All memberships terminated by April 1, 2001.

RETIREMENT PLAN AND OTHER EMPLOYEE BENEFITS

The Company has no employees. Any services performed on behalf of the HMO are provided by employees of Victory Management Services, Inc. under recitals of a service agreement discussed under the caption, "Agreements with Parent, Subsidiaries and Affiliates".

LOSS EXPERIENCE

As developed from applicable amounts included in the Company's annual statements filed with "The Department of Commerce and Insurance" for the State of Tennessee, the ratios of net losses incurred to net premiums earned for the period subject to this examination were as follows:

<u>Year</u>	<u>Losses Incurred</u>	<u>Premiums Earned</u>	<u>Loss Ratio</u>
2002	(\$1,799,106)	0	n/a%
2003	<u>(179,009)</u>	<u>0</u>	n/a%
Total	(\$1,978,115)	\$0	n/a%

The negative incurred loss during the 2002 and 2003 years is related the redundant development of outstanding claim reserves as all claims were subsequently paid after the HMO ceased writing new business and cancelled all membership contracts.

ACCOUNTS AND RECORDS

During the course of examination, such tests and audit procedures were made as were

considered necessary, including substantial verification of postings, extensions and footings and reconciliation of subsidiary ledgers to control accounts where necessary. General ledger trial balances were reconciled with copies of annual statements for the years 2002 and 2003.

Accounting records conform to generally accepted insurance accounting practices and appear to properly reflect the operations during the period under examination and the status of the HMO at the date of examination.

The HMO does not file a Risk Based Capital Report due to its inactive status. It does compute the risk based capital amount in compliance with annual statement instructions. "The Department of Commerce and Insurance" has exempted the HMO from filing an actuarial opinion as indicated in its email dated January 2, 2003. The Company does not meet the threshold requirements of Tenn. Comp. R. & Regs. Tit. Dep't of Commerce and Ins., ch. 0780-1-65.02 (2) and therefore is not required to file an annual audit report prepared by an independent accounting firm.

Books and records of the Company are kept at the home office location:

215 Centerview Drive, Suite 300
Brentwood, TN 37027

STATUTORY DEPOSITS

In compliance with statutory requirements, the Company maintained the following deposits at December 31, 2003:

<u>Where Deposited and Description</u>	<u>Par Value</u>	<u>Statement Value</u>	<u>Market Value</u>
Tennessee			
FNMA 5.125%, due 2/13/2004	\$905,000	\$909,677	\$905,000
Total general deposits held for the benefit			
of all enrollees of the HMO	<u>905,000</u>	<u>909,677</u>	<u>905,000</u>
Total	<u>\$905,000</u>	<u>\$909,677</u>	<u>\$905,000</u>

AGREEMENTS WITH PARENT, SUBSIDIARIES AND AFFILIATES

The HMO meets the definition of a holding company pursuant to Tenn. Code Ann. § 56-11-201 (b) (5) which specifically defines a "health maintenance organization holding company system".

The HMO is managed by Victory Management Services, Inc. (VMS), formerly known as Vanderbilt Management Services Inc. (used same synonym VMS). A Management Services Agreement between Vanderbilt Management Services, Inc. (VMS) and the HMO effective December 21, 2000 was approved by "The Department of Commerce and Insurance" on November 21, 2000. The parties intend that VMS manage the HMO as its business operations wind-down and the HMO becomes inactive in the market place. Vanderbilt Health Services, Inc. the parent of the HMO paid VMS a final fixed management fee of \$5,500,000.

The original management agreement dated June 9, 1994 provided for a base fee contingent on the number of enrollees in the HMO, plus an incentive fee based on certain performance measures. After the number of enrollees reaches a specified level, the agreement provides for a fee based on a percentage of revenue. The agreement was not submitted to the Commissioner for approval until May 7, 1996. Formal approval was granted July 3, 1996. This original agreement was between THG Management Services, Inc. and the HMO. On March 12, 1997, the HMO purchased one hundred percent of the issued and outstanding stock of THG Management Services, Inc. for \$8,615,000 and changed the name to Vanderbilt Management Services, Inc.

Claims handling services are handled under a Managed Care Agreement with Perot Systems formerly known as Shared Medical Systems Corporation. By virtue of an amendment made as of September 30, 2000, this agreement added the assignor "Vanderbilt Management Services, Inc." The original agreement was made as of February 12, 1999 with Vanderbilt Health Plans, Inc. The cost is on a fee per member basis. Perot handled the claims through runoff and continues to provide lag reports to the HMO. This agreement has never been between the HMO and Shared Medical Services. It does not require approval of "The Department of Commerce and Insurance".

PECUNIARY INTEREST - TENN. CODE § 56-3-103

The HMO has no employees, only five members of the Board of Directors and two officers who are also board members. No salary or fee is paid by the HMO to any officer or director or employee. These same individuals would also be party to any conflict of interest policy which is in place for employees and officers of Vanderbilt University.

Additionally, Tenn. Code Ann. § 56-32-221 (a) states “Except as otherwise provided in this part, provisions of the insurance law, and provisions of hospital or medical service corporation laws are not applicable to any health maintenance organization granted a certificate of authority under this part”.

COMMISSION EQUITY

No excess of loss agreements were in effect at December 31, 2003; therefore, no commission equity could exist in ceded unearned premium. In this scenario, there would be no ceded unearned premium.

DIVIDENDS OR DISTRIBUTIONS

During 2003, extraordinary dividends of \$11,262,500 were paid to the stockholder. \$6,828,500 of this amount was approved via letter from the Commissioner of Commerce and Insurance of the State of Tennessee dated November 26, 2002. \$4,434,000 was approved July 10, 2002 via letter from the Commissioner of Commerce and Insurance of the State of Tennessee.

LITIGATION

As of December 31, 2003, the Company had no pending litigation which would adversely affect the financial condition of the Company.

SUBSEQUENT EVENTS

None

FINANCIAL STATEMENT

There follows a statement of assets, liabilities and statement of income at December 31, 2003, together with a reconciliation of capital and surplus for the period under review, as established by this examination:

ASSETS

	<u>Ledger Assets</u>	<u>Non-Ledger Assets</u>	<u>Assets Not Admitted</u>	<u>Net Admitted Assets</u>
Cash and short-term investments	\$1,744,913			\$1,744,913
Investment income due and accrued	<u>17,522</u>			<u>17,522</u>
Totals	<u>\$1,762,435</u>	<u> </u>	<u> </u>	<u>\$1,762,435</u>

LIABILITIES, SURPLUS, AND OTHER FUNDS

Claims unpaid	\$0
Unpaid claim adjustment expenses	0
Aggregate policy reserves	0
Aggregate claim reserves	0
General expenses due or accrued	<u>0</u>
Total Liabilities	0
Common capital stock	\$108,695
Gross paid in and contributed surplus	93,686,074
Aggregate write-ins for other than surplus funds (dividend to Vanderbilt)	(15,633,500)
Unassigned funds (surplus)	<u>(76,398,834)</u>
Total capital and surplus	1,762,435
Totals	<u>\$1,762,435</u>

STATEMENT OF REVENUE AND EXPENSES

	Uncovered	Total
Member months	0	0
Net premium income	\$0	<u>\$0</u>
Total revenues	0	0
<u>MEDICAL AND HOSPITAL</u>		
Hospital/medical benefits	(178,449)	(178,449)
Other professional services	0	0
Outside referrals	0	0
Emergency room and out of area	0	0
Aggregate write-ins for other medical and hospital	<u>(560)</u>	<u>(560)</u>
Subtotal	(179,009)	(179,009)
<u>LESS</u>		
Net reinsurance recoveries	0	0
Total medical and hospital	0	0
Claims adjustment expenses	0	0
General administrative expenses	25,039	25,039
Increase in reserves for accident and health contracts	<u>0</u>	<u>0</u>
Total underwriting deductions	(153,970)	(153,970)
Total underwriting gain or loss	153,970	153,970
Net Investment income earned	51,783	51,783
Net realized capital gains or losses		<u>0</u>
Net investment gains or losses	51,783	51,783
Net income or (loss) before income taxes		205,753
Federal income taxes incurred		<u>0</u>
Net income		<u><u>\$205,753</u></u>

CAPITAL AND SURPLUS ACCOUNT

Surplus as regards policyholders, December 31 prior year		\$12,812,328
Net income	\$205,753	
Change in net deferred income tax	0	
Change in non-admitted assets	6,854	
Cumulative effect of changes in accounting principles	0	
Dividend to stockholders	(11,262,500)	
Change in surplus as regards policyholders for the year		<u>(11,049,893)</u>
Surplus as regards policyholders, December 31 current year		<u>\$1,762,435</u>

**RECONCILIATION OF CAPITAL AND SURPLUS
FOR THE PERIOD UNDER EXAMINATION**

Surplus as regards policyholders December 31,	<u>2002</u>	<u>2003</u>
Previous Year	<u>\$10,865,191</u>	<u>\$12,812,328</u>
Net Income	1,949,935	205,753
Change in net deferred income tax	0	0
Change in nonadmitted assets	(2,798)	6,854
Transferred from capital	0	0
Cumulative effect of changes in accounting principles	0	0
Dividends to stockholders	<u>0</u>	<u>(11,262,500)</u>
Surplus as regards to policyholders December 31		
Current Year	<u>\$12,812,328</u>	<u>\$1,762,435</u>

**ANALYSIS OF CHANGES IN FINANCIAL STATEMENT AND COMMENTS
RESULTING FROM EXAMINATION**

None

**SUMMARY SCHEDULE FOR "ANALYSIS OF CHANGES
IN FINANCIAL STATEMENT AND COMMENTS RESULTING FROM
EXAMINATION" AS THEY AFFECT SURPLUS**

None

COMMENTS AND RECOMMENDATIONS

Comments:

- The HMO is complying with Tenn. Code Ann. § 56-32-212 by maintaining the required net worth and trust deposit with "The Department of Commerce and Insurance" in order to maintain its Certificate of Authority. A decision has not been made by management whether to ultimately surrender the Certificate of Authority or market the authority to another qualified party. The HMO presently plans to remain inactive. No enrollees have been in the organization since April 1, 2001. No active claims remain open.

Recommendations:

- None

CONCLUSION

Insurance examination practices and procedures, as promulgated by the National Association of Insurance Commissioners, have been followed in connection with the verification and valuation of assets and the determination of liabilities of Health 1·2·3, Inc. of Nashville, Tennessee.

In such manner, it was determined that, as of December 31, 2003, the HMO had admitted assets of \$1,762,435 and liabilities, exclusive of capital, of \$0. Thus, there existed for the additional protection of the policyholders/enrollees, the amount of \$1,762,435 in the form of common capital stock, gross paid-in and contributed surplus, and unassigned funds (surplus).

The courteous cooperation of the officers and employees of the HMO extended during the course of the examination is hereby acknowledged.

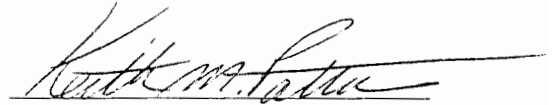
Respectfully submitted,

A handwritten signature in cursive script, appearing to read "Keith M. Patterson".

Keith M. Patterson
Insurance Examiner
State of Tennessee
Southeastern Zone, N.A.I.C.

AFFIDAVIT

The undersigned deposes and says that he has duly executed the attached examination report of Health 1·2·3, Inc. dated September 10, 2004, and made as of December 31, 2003, on behalf of "The Department of Commerce and Insurance", State of Tennessee. Deponent further says he is familiar with such instrument and the contents thereof, and that the facts therein set forth are true to the best of his knowledge, information and belief.



Keith M. Patterson
Insurance Examiner
State of Tennessee
Southeastern Zone, N.A.I.C.

Subscribed and sworn to before me

this 10th day of

September, 2004

Notary Carlene J Bennett

County Davidson

State Tennessee

Commission Expires Sept. 20, 2005

ORGANIZATIONAL CHART

